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North Carolina School Mental Health Initiative

Introduction

Current status of mental health in children and youth

Most elementary and secondary schools in the United States provide inadequate mental health supports, despite the reality that the number of students in need of services continues to outpace available resources (Foster, Rollefson, Doksum, Noonan, & Robinson, 2005). This problem is by no means a recent development. In 2002-2003, two-thirds of school districts nationwide reported the need for mental health services had increased since the previous year, while funding for these services had decreased in that time (Foster et al., 2005). More recently and closer to home, Splett et al. (2014) found that approximately 19% of school-age children in North Carolina have at least one emotional, behavioral, or developmental disability. In this study it was also reported that approximately 6% of North Carolinian youth used drugs or alcohol within the previous 12 months.

Research conducted on a national sample of 10,000 adolescents, aged 13-18, suggested that approximately 14% – 32% had a mood disorder or anxiety disorder during their school age years. Of these adolescents, only approximately 38% received any mental health treatment. In 2014, approximately 2.8 million adolescents, aged 12 – 17, reported a major depressive episode in the prior year (National Institute of Mental Health, 2016). Nationally, more youth are becoming depressed. There was a 1.2 percent increase in youth with depression, and a 1.3 percent increase in youth with severe depression between 2010 and 2013 (Mental Health America, 2016). These data are linked to obvious adverse effects on educational outcomes and negative consequences. The high school dropout rates for students age 14 and older with a mental health issue was found to be 50% (National Alliance on Mental Illness, 2015). Suicide, which is a potential consequence of the interaction of mental disorders and other factors, was the second leading cause of death among people aged 10–24 years in 2014 (Centers for Disease Control and Prevention [CDC], 2016b). In North Carolina the total number of youth suicides is increasing: from 23 in 2010, to 34 in 2013, and 46 in 2014 (North Carolina Child Fatality Task Force, 2016).

Amongst younger children, mental health problems exist at alarming rates as well. According to data aggregated nationally by the CDC in 2011–12, 14.2% of children (aged 2–8) are reported to have a mental, behavioral, or developmental disorder (MBDD) (Bitsko, Holbrook, Robinson, et al., 2016). Data collected for this report included prevalence rates for North Carolina. Specifically, in North Carolina, approximately 15.6% of children were reported to have a mental, behavioral, or developmental disorder. Of these children, 21.2% have no insurance and 41.7% have no [medical home](#) (Bitsko et al., 2016). At the national level, results of the research has indicated that 50% of children with mental health problems do not use mental health services (National Institute of Mental Health, 2016).

Access to care

Access to mental health services is not evenly distributed across society. Many of the children with the greatest need for services are the ones with the least access, often due to financial constraints, lack of insurance coverage, lack of transportation to and from service providers, or unavailable services. In North Carolina, 21.4% of children reported to have a mental, behavioral, or developmental disorder live in poor communities and 11.2% of them have at least one parent with mental health concerns as well (Bitsko et al., 2016). According to several studies, 13%–20% of children living in the United States experience a mental disorder in a given year (Angold et al., 2002; CDC, 2016a; Merikangas et al., 2010). Of youth requiring mental health services, over 75% do not receive treatment (Goodman et al., 1997; Grunbaum et al., 2004; Marsh, 2004). Translation of these numbers within the context of our school-aged children and youth is as follows:

- Of the 1,513,053 children in NC public schools, up to 302,610 of them will experience a mental health disorder in a given year
- Of these 302,610, only 75,652 of them will receive treatment

What will happen to the 226,957 who do not receive treatment? According to Mental Health America (2016), North Carolina ranks 36th in the nation in prevalence of mental illness and access to care for youth, worse than West Virginia, Georgia, and Kentucky.

Students' mental health and academic outcomes

There is substantial support of the co-occurrence of risk across psychological, social, and academic domains, in that students with problems in one area tend to also demonstrate problems in other areas. Additionally, well-adjusted children are often defined by positive social and academic competence and minimal problems in terms of externalizing or internalizing symptoms (Valdez, Lambert, & Jalongo, 2011). Mental and behavioral wellness is directly linked to overall positive student achievement, school climate, high school graduation rates, and the prevention of risky behaviors, disciplinary incidents, and substance abuse (Center for Health and Healthcare in the Schools, 2014).

In 2003, the New Freedom Commission on Mental Health recommended in its report to the President of the United States that school-based mental health programs must be improved and expanded. As schools have attempted to meet the mental health needs of children and youth, they tend to offer a myriad of programs designed to address mental health needs, including the Character Education curriculum used in the classroom; health education; anti-bullying programs; adolescent pregnancy prevention programs; safe and drug-free school programs; counseling provided by school counselors, social workers, psychologists and nurses; classroom mentors; licensed therapists providing services to students in the school setting; Response to Intervention (RtI); Positive Behavior Interventions and Supports (PBIS) – the list could go on.

Although many of the aforementioned programs are viewed as effective, these types of programs and efforts are frequently viewed as “add-ons” rather than as an integral part of the student’s education since they are not “academic” (Adelman & Taylor, 2006). There are seldom coordinated efforts demonstrated between the

support programs that exist and even less coordination between these types of programs and curriculum planning within the school. As a result of a lack of intentional coordination within the existing instructional curriculum and supports developed in a school, programs such as those referenced above are often not maintained when changes in funding, personnel, policies, leadership, or even a lack of teacher “buy in” adversely impact the long-term sustainability of these school mental health paradigms.

Thus, although providing mental health services to youth in schools is logical, historically common (Burns et al., 1995; Rones & Hoagwood, 2000; Farmer, Burns, Philip, Angold, & Costello, 2003) and addresses a major barrier of access to care, the scope and reach of school mental health programming is often limited, underdeveloped, or not well integrated across systems of care. In a recent study that examined the extent to which school mental health and PBIS services were evident in the Carolinas, Splett and colleagues (2014) reported that SMH of any type was implemented in only 15% of the total number of schools in North Carolina. Although better, the state of PBIS implementation in North Carolina was limited to only 29% of the schools statewide and the majority of PBIS programs that were present, existed primarily in elementary (67%) or middle schools (20%). In terms of the number of schools in North Carolina that reported having both SMH and PBIS services, only about 4% described having these systems in place at the same time (Splett et al., 2014). Despite these discouraging statistics, there have been some integrated SMH models in North Carolina that have shown considerable promise, albeit on a smaller scale. For instance, in western North Carolina, partnerships entitled Assessment, Support, and Counseling (ASC) Centers have been developed over the past decade (Michael, Renkert, Wandler, & Stamey, 2009) and found to be effective in at least 3 school districts (e.g., see Albright et al., 2013). There have also been successful efforts reported in designing crisis protocols for schools (e.g., Michael et al., 2015) and in providing effective intervention for students who are experiencing depressive symptoms (Michael et al., 2016). Similarly, Golden, Ongsoco, and Letchworth (2013) described their efforts to enhance school-based mental health services in under-resourced areas of Eastern North Carolina. In both cases, these programs were embedded in rural communities with active university training programs committed to enhancing the health of its students and families, promoting economic growth, and providing sustained workforce development.

When considering the state of children/adolescent mental health, lack of adequate access to effective services that exist, and the interrelationship that exists between social-emotional functioning and academic functioning, a logical conclusion has been to provide mental health supports and services to children and youth within the context of the school setting. Although attempts have been made to address school mental health through add-on programs within schools and/or agreements between schools and community providers to bring therapeutic services to the students, potential solutions have yet to be applied in a consistent and sustained way to address the needs of our most vulnerable population, our children and youth. In alignment with a [Multi-Tiered System of Support](#) and the [Whole School, Whole Community, Whole Child Model \(WSCC\)](#), a comprehensive, consistently funded and implemented approach is necessary to establish effective, mental health services for children and adolescents.

Opportunities for well-coordinated mental health supports

Recent policies have added strength to the movement towards serving mental health needs in schools across the nation. On December 10, 2015, President Obama signed the bipartisan [Every Student Succeeds Act \(ESSA\)](#) which reauthorizes the Elementary and Secondary Act of 1965. ESSA references specialized instructional support personnel (SISP) more than forty times. It defines specialized instructional support personnel as school counselors, school nurses, school social workers, school psychologists, and other state-certified or licensed mental health professionals. In particular, ESSA allows specialized instructional support personnel to be part of a state and district school improvement plan, to identify students at risk for school failure and to address school climate and school safety in addition to mental and behavior health of students (National Association of School Psychologists [NASP], 2016). To help schools improve conditions for learning, ESSA authorizes various funding streams that states and districts can use to implement:

- positive behavior interventions and supports or other activities to address skills such as social emotional learning, conflict resolution, effective problem solving, and appropriate relationship building;
- trauma informed practices, and mental health first aid;
- comprehensive school mental health services;
- efforts to improve school climate, school safety, and crisis prevention, intervention, and response;
- improve school community partnerships

The review of past efforts to address school mental health through a fragmented or reactive perspective will better inform future decisions with regard to how North Carolina cares for the mental health of children and youth. It is clear through the existing data that the fragmented and reactive approaches have not proven successful in improving mental health outcomes for our children and youth. Given the evidence regarding the interrelatedness of academic outcomes and mental health/well-being of students, an embedded approach within an existing system is required.

Schools as the existing system

Most children and youth spend an average of 6.5-7 hours of their days, 5 days a week, within a school environment. Schools offer unparalleled access to students in order to address both academic and mental health needs, which are intricately related (New Freedom Commission on Mental Health, 2003). Schools have been identified as the natural and best setting for mental health prevention and treatment services (Anglin, 2003). School-based mental and behavioral health services encompass more than the intensive therapeutic supports provided to students who are identified with psychiatric disorders and are often served by community-based providers. Comprehensive school-based mental health services delivered within a multitiered system of supports (MTSS) include a range of layered services and supports that promote mental and behavioral wellness among *all* students. This includes, but is not limited to, students dealing with depression and anxiety, emotional and behavioral disorders, trauma, loss and grief, family problems, and stressors due to influences such as poverty and homelessness (NASP, 2015). Additionally, members of the existing school staff have a background

in understanding and supporting the mental health needs of children and youth. School-employed mental health professionals (school counselors, school nurses, school psychologists, school social workers) have specialized training in meeting the mental and behavioral health needs of students (NASP, 2015).

Examples of school mental health service provision has been established in studies conducted by Friedrich (2010), where it was reported that approximately 50% of school psychologists work week involved mental health services, such as consultation with school staff and problem-solving teams, social–emotional–behavioral assessment, and various forms of counseling. In another example, Bergren (2012) reported that school nurses spend 32% of their time providing mental health services and are often the first to assess and identify subtle signs of mental health needs exhibited as external symptoms and behaviors. For students with the most intensive needs, the existence of school based mental health centers are 21 times more likely to be utilized by students than other types of mental health treatment centers (Juszczak, Melinkovich, & Kaplan, 2003). Access to school-based mental health services is linked to students’ improved academic outcomes (Michael et al., 2013) and enhanced physical and psychological safety (Ballard, Sander, & Klimes-Dougan, 2014; Bruns, Walrath, Glass-Seigel, & Weist, 2004). If schools are truly going to address the many reasons that students are not succeeding in school, it is time to reassess how to achieve that mission (Center for Mental Health in Schools, 2007). There are currently four states that serve as examples of a comprehensive approach to student learning supports: Iowa’s “System of Learning Supports: A State Department Education Initiative” (Iowa Department of Education, 2004), Hawaii’s “Comprehensive Student Support System: A Statewide Initiative” (Hawaii Department of Education, 2000), Michigan’s “Safe and Supportive Schools” (Michigan Department of Education, 2015), and Alabama’s “Unified and Comprehensive System of Learning Supports” (Alabama State Department of Education, 2013).

Defining and understanding school mental health services

To say that the term “school mental health services” needs a clearer conceptual framework is an understatement. Similar terms are used interchangeably in the field and in literature: school mental health, school-based mental health, expanded school mental health and comprehensive school mental health. Other terms have entered into the discussion: social-emotional learning, psychological well-being, mental healthiness, psychological/crisis recovery.

In examining the existing literature, the difficulty in defining school mental health services is clear. The discussion may focus around *components* of school-based mental health, the *range* of school-based mental health services (from universal education programs to specific therapies delivered), or school-based mental health according to *who is delivering the service* and *where the service is delivered*. The lack of a clear definition leaves many questioning, “How are we to talk about ‘school mental health services’ so that all involved may have a common understanding?”



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Background of the North Carolina School Mental Health Initiative

Bring stakeholders together to establish common language and a clearly defined mission

As a result of the continued and ever increasing mental health challenges children and youth face, and the consequential impact on overall well-being, a group of stakeholders representing diverse backgrounds and experiences related to the provision of mental health services to children and youth came together in June 2015. The North Carolina School Mental Health Initiative (NC SMHI) was established as a multi-disciplinary partnership with broad representation consisting of public educators, community-based mental health clinicians, lawyers, advocates, university faculty, and parents. The NC SMHI agreed on the relevance of the work and quickly asserted themselves to be purpose driven and outcome oriented, readily establishing a mission and agreed upon definition of mental health services.

It is the mission of this partnership to develop recommendations for policy and/or legislative changes to ensure that public school students in North Carolina have equitable access to a full continuum of high-quality and well-coordinated mental health services.

For purposes of the NC SMHI's work, mental health services are services that:

- *Promote* healthy development of social, emotional, and/or behavioral functioning
- *Prevent* problems with social, emotional, and/or behavioral functioning
- *Respond* to students experiencing concerns or problems with social, emotional, and behavioral functioning
- *Prevent and treat* substance abuse

Gather/analyze state level data to inform the work

The NC SMHI partnership agreed that, although national and state level statistics were available to review, it was equally important to collect and analyze state level data regarding *perceptions of* and *access to* mental health services for NC children and youth. As a result, the first phase of work involved collecting state level data through a systematic environmental scan in order to elucidate a clear picture of the strengths and needs related to the provision of school mental health services across the state. The scan included the use of two surveys and six focus groups to collect the necessary information from stakeholders statewide. The surveys and focus groups served as a critical first step in the development of recommendations for policy and/or legislative action on behalf of North Carolina children and youth {see Appendix A}.

Summary of state level perceptions of mental health services in schools:

Survey questions were asked pertaining to the continuum of supports that may or may not be present currently in the respondents' school systems. The results of these survey items are organized by respondent group, beginning with the school staff, followed by community providers, and finally parents. Each group was asked similar items, however, not all items were exact due to the differing circumstances of each group.

The responses by *school staff*, broadly, indicate that although some basic features of socio-emotional support have been implemented, other elements of effective mental health support are lacking. The majority of school based respondents (SBR) were school counselors followed by school nurses and school psychologists. It should be noted that 247 SBR indicated their role as “other,” leaving some questions as to who these stakeholders are. With regard to basic universal prevention, only 91 (or 5%) of the 1823 school based respondents reported that their schools used a universal screening tool for mental health, however, over half were aware of programs that could be implemented to improve outcomes. The majority of school based respondents reported the use of PBIS and data driven decision making for mental health; however, 80% also indicated that the existing staffing ratios of specialized instructional support personnel to deliver a full range of mental health services are inadequate. With regard to collaboration, despite the majority of SBRs (76.9%) reporting that collaborations exist with outside agencies, only 51% reported that their schools had effective partnerships with parents. It was unclear whether the collaborations that do exist with outside agencies are effective. When asked if outside agencies attended collaborative meetings 25% of SBR responded “don’t know” and 35% responded “no.”

Community based providers (CBP) were also asked about the basic process of the continuum of supports. Perhaps predictably, most CBP responded that they do not engage in universal screening, and staff were reported to have good knowledge in how to respond to referrals. In addition, a majority of CBPs reported that their parent/family collaboration was effective. When asked about equal access to school based services, the responses were split. 53% indicated that there was unequal access, while 46% responded that access for children was equal. Surprisingly, when asked the same questions about *community* services, the majority responded that access was unequal. With regard to collaboration in schools, 74% of CBP reported some collaboration, with 65% rating it as “somewhat effective.” Furthermore, 61% indicated they have a “point person” at the school/district. When specifically asked about formal evaluation of student outcomes in response to the social emotional services provided, a mere 16.9% of provider response indicated a system of accountability in place tied to student outcomes.

With regard to *parent* respondents, when asked about screening processes, approximately half (52%) of parents reported their children receive screeners (either in school or through a community provider), and of those, 89% of parents indicated that they were made aware of the results. 61% of parent respondents also reported that they have been contacted by the school regarding their child’s behavior. When asked whether their child’s school offers any programs or services to treat social-emotional health, only 25.7% of parents responded “yes”, while 41.7% indicated “no” and 32.6% indicated “I don’t know.” A key factor in the provision of school based services is access to providers who are already there. When asked their opinion of whether their child’s school has enough personnel and resources to effectively support students with mental health needs, an overwhelming 80.5% of parents responded “no.” Further, a similar 80.9% of parents also indicated that their child’s school is not sufficiently funded to assist students with mental health needs. When asked specifically about substance abuse services, almost half (48.3%) of parents indicated that they do not know how and where to seek help. With regard to access to services, the 49.8% of parents reported that there is inequity in access to services in school, while 60.8% of parents reported inequity in access to services in the community. With regard

to partnerships with schools, 35.8% of parents indicated that they perceive their child's school as an effective partner with them in supporting their child's social-emotional health. Finally, when asked whether their child's school and/or community-based agency has ever asked their opinion about the mental health services provided to their child, 81.75% of parents responded "no."

These data provide additional insight, from a North Carolina perspective into the fragmented and reactive system of mental health and substance abuse services that exists. Although evidence continues to point in the direction of prevention and early intervention as the most effective way to address mental health, there is very little being done in terms of educating and screening our school age youth in this area. Evidence-based programs exist and there appears to be a familiarity of them; however, the delivery of mental health services in a systematic way, through an identified continuum of supports is not clearly reported through any of the 2,465 stakeholders who completed the environmental scan survey. In addition, there appears to be some level of agreement that inequity exists in access to mental health services across the school and the community. Within the existing system, there also does not appear to be any consistent method (by school systems or community providers) in place to assess the effectiveness of the services that are provided.

Identify/organize/prioritize needs based on data collected

Once these data were collected and analyzed, the partnership collectively generated six domain areas as the basis for their recommendations. The initial work group structure was reorganized to reflect six separate subcommittees that would then focus on each respective domain area in developing actionable recommendations that aligned with the mission of the partnership. The subcommittees were designated around the following domains that were identified as priorities:

- 1) Develop a Continuum of Mental Health Services and Supports for Students
- 2) Advance Universal Positive Mental Health and School Climate/Safety
- 3) Develop a Sustainable Workforce of Services and Supports within School and Community Providers
- 4) Create Effective Stakeholder Engagement and Collaboration (Family, Students, Schools, Agencies)
- 5) Establish Braided and Sustained Funding, Including Private Insurance Coverage
- 6) Create a Comprehensive Evaluation and Accountability System of Mental Health Services and Student Outcomes

Develop/summarize/present actionable steps that are aligned with the mission

This detailed report including a series of practical recommendations for policy and lawmakers has been the outcome of the work beginning June 2015 through October 2016. The recommendations that have been established serve as the partnership's basis in advocating for the necessary changes that will allow all school age children and youth equitable access to a continuum of high quality and well-coordinated mental health and substance use services.

NC School Mental Health Initiative Recommendations

1. Create a Continuum of Supports and Services for Student Mental Health and Substance Use

Issue:

Currently, mental health and substance use services across NC schools are fragmented, reactive, or non-existent. Too often, mental health and substance use needs are not addressed until the student and family are in crisis and academic progress is impacted.

Solution:

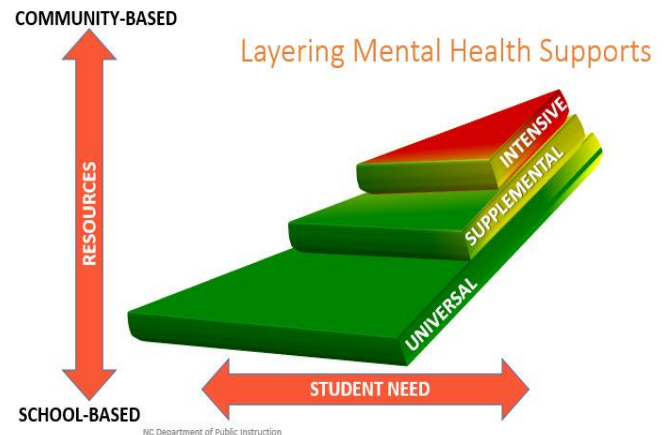
A continuum of mental health and substance use supports is necessary for all students to be fully engaged in the learning process.

Rationale:

A continuum encompasses education, universal screening, and appropriate services and supports for all children in response to varying levels of need.

Implementation Strategies:

- Public schools, families, community providers, Managed Care Organizations and other payors will jointly create a plan for meeting the mental health and substance use needs of all NC public school students. The continuum will include:
 - Education of staff and students pre-K-12
 - Education will ensure that all staff members are adequately prepared to support the needs of their students, the stigma of “mental health” is diminished, and the term “mental health” becomes a common element embedded within the school environment.
 - Healthy school communities
 - A healthy school community fosters a positive school climate that meets the social and emotional needs of all students and promotes the infusion of school-wide social-emotional learning and resilience building skills.
 - Universal screening
 - Universal screening identifies a student’s barriers to academic, behavioral, social, and emotional success at critical development periods.
 - Supplemental supports
 - Supplemental supports will be provided to students identified with emerging mental and behavioral health needs.
 - Intensive services for both the students and family



Implementation Strategies (*continued*):

- Intensive services will address identified mental and behavioral health needs and may include crisis intervention and/or direct therapeutic supports appropriate to each individual student and situation.
- To ensure accountability, the plan will include a system to evaluate the quality of mental health and substance use services and measure student outcomes.

2. Make it Sustainable

Issue:

Students need equitable access to a continuum of supports and services regardless of their ability to pay. Changes in funding structures are needed in order to provide these services and staff them appropriately.

- Students face unnecessary barriers to accessing appropriate supports and services funded by their private and public health insurance in the school setting.
- Schools need additional qualified providers to adequately support the mental health and substance use needs of students to create successful learners.

Solution:

Children and families need benefits that are accessible across various entrance portals and regardless of county of residence. To that end, a workforce of school providers that is staffed in sufficient numbers as well as promotion, expansion and modeling of existing university-school partnerships is needed.

80% of school based respondents indicated that the existing staffing ratios of specialized instructional support personnel to deliver the full range of mental health services are inadequate.

NC SMHI Environmental Scan Survey
March 2016

Rationale:

Federal mandates require uninterrupted provision of educational and health services, yet current funding structures promote disconnected, splintered mental health and substance use care for children.

Implementation Strategies:

- Create incentives for Memorandums of Agreement between all collaborators (e.g., Division of Medical Assistance, Department of Public Instruction, Managed Care Organizations, public schools) to ensure coordination of funding and quality services.
- Eliminate barriers to students accessing services at school through Medicaid including:
 - Remove the requirement for services to be included in an Individual Education Program (IEP) for reimbursement

Implementation Strategies (*continued*):

- Open access of reimbursement to public schools for services provided to Health Choice beneficiaries
- Discontinue state Medicaid policy interpretation which counts school provided/educational services against benefits in other settings or include school provided/educational services in the determination of medical necessity
- Create infrastructure for public schools to be recognized by commercial healthcare insurance companies as providers of behavioral health care services for children.
- Improve student access to adequately trained school health professionals in NC public schools by employing in sufficient numbers, adequately trained and licensed Specialized Instructional Support Personnel (SISP) (school counselors, school nurses, school psychologists, school social workers) {see Appendix B}.
- Ensure that a state level infrastructure exists to provide consistent and cohesive support to Specialized Instructional Support Personnel.
- Replicate sustainable practices, such as existing university-school partnerships.
- Include a mental health and substance use component within existing professional development requirements of all involved professionals (members of local boards of education, school administrators, school resource officers, school counselors, school nurses, school psychologists, and school social workers).

3. Engage All Stakeholders

Issue:

Families, students, schools, community providers and cross-systems providers are disconnected as a result of the inadequate, fragmented, difficult to access, and/or duplicated mental health and substance use supports and services for students.

Solution:

Engage all stakeholders to create and sustain collaborative, coordinated behavioral health supports and services for students.

Rationale:

Schools must partner with families and community service providers to effectively address the mental health and substance use needs of students. This is consistent with *Governor's Task Force on Mental Health and Substance Abuse* report finding; "Many children have a variety of physical, mental, social, emotional, educational and developmental needs. Providing effective help to children and their families requires sharing information across the many agencies and multiple systems that serve them."

The research tells us...

- Parents' alliance with a school mental health clinician predicts whether youth and families use the skills taught during interventions
- Collaborating with caregivers in the treatment process reduces the amount of time students spend in the treatment environment
- When clinicians seek feedback from caregivers, the caregivers are more likely to feel that their child's needs are being met
- Incorporating family feedback into treatment processes creates a sense of shared responsibility for the well-being of the child receiving services
- Demographic characteristics are not associated with level of treatment involvement

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*Handbook of School Mental
Health: Advancing Practice and
Research*

Implementation Strategies:

- Dedicate school resources to build partnerships with families and community mental health and substance use providers.
- Establish, leverage, and/or strengthen local collaboratives to ensure consistent participation by local mental health and substance use partners/stakeholders.
- Map and communicate local mental health and substance use supports and services for students, including providers.
- Expand managed care organizations and other payors visibility, involvement, and collaboration with local mental health and substance use partners/stakeholders.
- Simplify family/student access to community mental health and substance use supports and services.
- Remove barriers to the exchange of information across schools, families, and agencies.

Appendix A

NC School Mental Health Initiative Data

The collection of state level data through a systematic environmental scan included the use of two surveys and six focus groups to collect the necessary information from stakeholders statewide. The initial structure of the work group teams within the SMHI partnership consisted of:

- The Survey Revision Team
- The Focus Group Team
- The Distribution Team
- The Research and Evaluation Team

Long Survey:

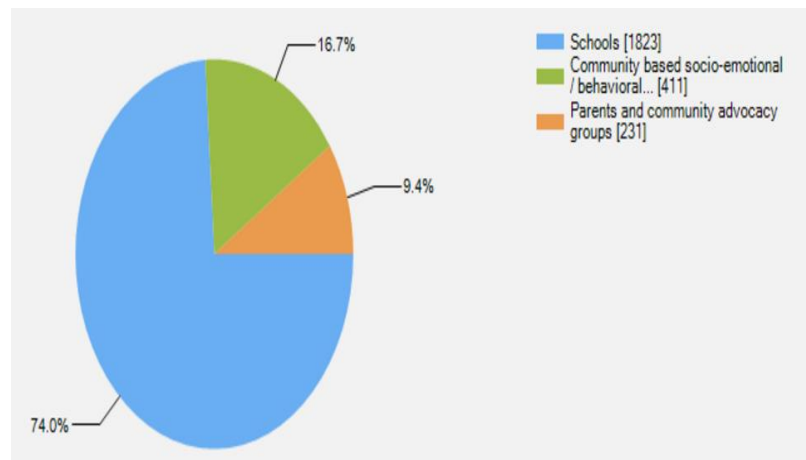
Survey items were developed by the NC SMHI and refined by a subcommittee. The survey was distributed via email to all members of the NC SMHI, who then sent it across all of their respective contact lists.

Additionally, the survey was directly distributed to the following groups:

- Children’s Development Services Agency
- El Centro Hispano
- El Pueblo
- Juvenile Crime Prevention Council
- North Carolina Academy of Family Physicians
- North Carolina Association of School Administrators
- North Carolina Collaborative
- North Carolina Council of Community Programs
- North Carolina Council on Exceptional Children
- North Carolina Department of Public Instruction, Exceptional Children Division Lists (internal staff and directors)
- North Carolina Department of Public Safety
- North Carolina Exceptional Children Advisory Council
- North Carolina Families United
- North Carolina Medical Society
- North Carolina School Counselor Association
- North Carolina School Psychology Association
- North Carolina School Resource Officer Association
- North Carolina School Social Work Association
- Public Health Nurses’ Directors
- School Health Advisory Councils
- Systems of Care Coordinators
- Western Youth Network

The survey was active from February 19, 2016 – March 7, 2016. In order to allow accessibility by a variety of stakeholders, a paper version was also distributed on March 1, 2016 and a Spanish version of the survey was also made available from March 3, 2016 – March 25, 2016.

Respondents were routed to one of three sets of items, depending on which stakeholder group they represented: public school systems, community agencies, or parents. A total of 2,465 responses were received and the distribution of the sample is indicated in the illustration to the right.



Focus Group Data Collection:

6 sessions held across the state:

- February 1st – Morganton, NC (n=18)
- February 2nd – Raleigh, NC (n=16)
- February 9th – Greensboro, NC (n=13)
- February 23rd – Wilmington, NC (n=21)
- March 14th – Webinar (n=5)
- April 14th – Jamestown, NC (n=32)

Similar to survey representation, subgroups consisted of:

- Schools (n=35)
- Community Agencies (n=34)
- Parents (n=36)
- Session length = 1 hour
- Method used = 3 standard discussion items
- Responses were collected via audio, later transcribed
- Note-taking was also used in conjunction with audio data collection

Thematic analysis of data collected across the six focus group sessions results are as follows:

- 1) *Discuss the barriers you see to the availability of mental health/substance abuse programs for children in the schools and community.*
 - a. Insurance (Mentioned 15 times; issue raised in all 6 focus groups)
 - b. Knowledge about “where to go” (Mentioned 9 times; issue raised in 5/6 focus groups)
 - c. Staff training/Staff turnover (Mentioned 13 times; issue raised in 5/6 focus groups)
 - d. Communication with families (Mentioned 15 times; issue raised in 5/6 focus groups)
 - e. Lack of substance abuse treatment (Mentioned 7 times; issue raised in 4/6 focus groups)

- f. Communication/relationships with agencies (Mentioned 7 times; issue raised in 3/6 focus groups)
 - g. Lack of qualified staff in an area (Mentioned 9 times; issue raised in 4/6 focus groups)
 - h. Function of school mental health providers (testing/attendance, no time for provision of quality services (Mentioned 5 times; issue raised in 3/6 focus groups)
- 2) *Discuss what you think is working to facilitate children getting the needed mental/health substance abuse services.*
- a. Professional Development (Mentioned 5 times; issue raised in 2/6 focus groups)
 - b. Relationships between schools and communities (Mentioned 11 times; issue raised in 5/6 focus groups)
 - c. School health centers on-campus (Mentioned 5 times; issue raised in 3/6 focus groups)
- 3) *How are school personnel, families and community agency staff informed about the various services and programs available for students with mental health needs? Is there a point person in the schools or community agencies that families know to contact about mental health services available for children?*
- a. No clear point person (Mentioned 8 times; issue raised in 6/6 focus groups)
 - b. Clear point person/people (usually school counselors, school social workers, and school psychologists) (Mentioned 8 times; issue raised in 5/6 focus groups)
 - c. Individualized process/Different based on district/school (no systematic process) (Mentioned 12 times; issue raised in all 6 focus groups)

Appendix B

Service Delivery Staffing Ratios for Specialized Instructional Support Personnel

School Counseling:

- The recommended staffing ratio for school counselors, as defined by the [American School Counselor Association](#) (ASCA), is one licensed/certified school counselor for every 250 students in order to provide comprehensive school counseling programs that support student and school success.
- When students require more intensive services, such as in schools with high populations of students with special needs and/or other at-risk factors that serve as barriers to education, the ratio of school counselors to students should be adjusted to allow for more direct service time to address student needs.
- The framework for comprehensive school counseling programs, including recommended ratios, can be found in more detail in [The ASCA National Model: A Framework for School Counseling Programs](#). The ASCA National Model is research- and evidence-based and currently in its third edition.
- In alignment with State Board of Education approved [professional standards](#) for school counselors, [N.C. G.S. 115C-316.1](#) states that "School counselors shall implement a comprehensive developmental school counseling program in their schools. Counselors shall spend at least eighty percent (80%) of their work time providing direct services to students."

School Nursing:

- Long standing staffing ratio standards were set by an expert panel of the [National Association of School Nurses](#) (NASN) at 1:750 for regular education students with a decreasing ratio based on the health acuity of the population served. Both NASN and the [American Academy of Pediatrics](#) have recently advised that ratio should more directly reflect workload and should, at minimum, be one full time school nurse per every school.

School Psychology:

- The recommended staffing ratio for school psychologists as defined by the [National Association for School Psychologists \(NASP\)](#) in the [Model for Comprehensive and Integrated School Psychological Services](#) is one school psychologist for every 500–700 students when providing a comprehensive range of services. This ratio, along with the standards for the profession, were developed through a rigorous and transparent 3-and-a-half-year process that included input from school psychologists, leaders, and affiliated group representatives.
- The recommended staffing ratio is aligned with the NC State Board of Education approved [Professional School Psychology Standards](#), which require school psychologists to provide comprehensive services as part of a multi-disciplinary team.

School Social Work:

- The recommended staffing ratio for school social workers is defined in a resolution statement by [School Social Work Association of America \(SSWAA\)](#) as one school social worker to 250 general education students or one school social worker per building serving 250 students or fewer. This recommendation is consistent with the roles and functions of the profession as delineated in the [SSWAA School Social Work National Practice Model](#) (2013).
- When students require more intensive services, such as student with disabilities and other specialized populations, the ratio of school social workers to students should be adjusted to ensure school social workers appropriate workloads in addressing students' needs.

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